

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 901 MACARTHUR BLVD MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This was for investigation of a State complaint.</p> <p>Complaint: #IN00132120 Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility Number: 005106</p> <p>Survey Date: 11/07/2013</p> <p>Surveyor: Sandra Nolfi, RN Public Health Nurse Surveyor</p> <p>Community Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules.</p> <p>QA: cloughlin 12/5/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE